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A County-State
COUNTY MEDICAL SERVICES PROGRAM
CMSP
Partnership in Health Care

CMSP Letter No.: 04-07
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TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: COUNTY MEDICAL SERVICES PROGRAM (CMSP) CHANGES REGARDING ELIGIBILITY

The purpose of this All County Letter (ACL) is to inform you and your staff of important eligibility changes to the CMSP. These changes were approved by the CMSP Governing Board on March 25, 2004, and are designed to reduce overall program and administrative costs so that program costs do not exceed available revenues. The effective date for these changes will depend on whether the county is part of the ISAWS or the CDS eligibility processing systems, as discussed later in this letter.

A Workgroup of the CMSP Governing Board's Eligibility Committee has been working on developing policy, manual updates, forms revisions, systems changes, conversion schedules, etc., related to these changes. Enclosed is a current list of policies that will be used to implement these changes. However, please be aware that this document is a work-in-progress and as the Workgroup identifies additional issues, the policies may be updated.

ELIGIBILITY CHANGES

The eligibility changes approved by the CMSP Governing Board include the following:

1. **Elimination of Eligibility for Individuals with Net-Non-Exempt Incomes Greater Than 200% of the Federal Poverty Level (FPL)**

Currently, there is no income limit on CMSP eligibility. Individuals with net non-exempt incomes above a specified maintenance need level may be eligible for CMSP with a monthly share-of-cost (SOC). The monthly SOC owed by a client depends on the level of net non-exempt income the individual has above the specified maintenance need level.

This change will restrict eligibility for CMSP to individuals who have net non-exempt incomes that are not greater than 200% of the federal poverty level. Individuals with net

non-exempt incomes over 200% of the federal level will no longer be eligible for any CMSP benefits.

2. Time-limited Certification Periods for CMSP Eligibility

Currently, individuals who apply for CMSP are determined eligible for one year, but must file a quarterly status report (QSR) to the county welfare department to report income, family and other changes. Failure to submit the QSR results in a termination of CMSP eligibility. In addition, CMSP clients currently have their continuing eligibility for services reassessed once a year, and individuals applying for CMSP have 90 days to file a request for a hearing on actions taken concerning their eligibility.

This change will limit CMSP eligibility to a specified time period based upon the CMSP aid code. CMSP beneficiaries will be required to reapply for CMSP to continue eligibility for the program beyond the certification period. Status reports and annual redeterminations will be eliminated.

Also as a part of the change to time-limited certification periods, the requirement that CMSP beneficiaries report changes to income and resources will be eliminated. In the application process, certain verifications will no longer be required. In addition, individuals applying for CMSP will have 30 days to file a request for a hearing on actions concerning their eligibility. Please see the enclosed policy list for clarification on these and other details.

Certification time limits will be determined by the client's aid code:

- Clients who are eligible for full scope CMSP benefits without a monthly SOC (aid codes 84 and 88) will be eligible/certified for six months;

- Clients who are eligible for full scope CMSP benefits with a monthly SOC (aid codes 85 and 89) will be eligible/certified for three months;

- Clients who are eligible for emergency services only, with or without a SOC, (aid code 50) will be eligible/certified for the month in which the application is made, and the month immediately following;

- Clients who are eligible for CMSP as a companion code to Medi-Cal long-term care (aid code 8f/53) will not be affected by this change.

EFFECTIVE DATES OF CHANGES

The CMSP Governing Board authorized these eligibility changes to become effective on or after July 1, 2004. The actual effective date will be based on whether the county is part of the ISAWS or the CDS eligibility processing systems.

ISAWS system changes are under development with the ISAWS Consortium. For ISAWS counties, the changes will take effect on December 1, 2004, for applications submitted on or after that date. As a part of this change:

- Conversion of the existing caseload of beneficiaries to the new rules will take place beginning November 30, 2004, through an automated process that includes notification to the beneficiaries regarding their eligibility status at that time.

- **Any applications dated on or after October 1, 2004 but not processed by December 1, 2004** will be subject to the new rules. (This policy, still under final development, is based on ISAWS system capability and procedure.) Therefore, it is very important for counties to process pending applications by November 30, 2004.

  Any applications dated before October 1, 2004, but not processed by December 1, 2004, will be manually processed under the prior eligibility rules.

Specific details and dates relating to CDS county implementation and caseload conversion are under development. Solano and Sonoma Counties, the two CMSP counties that participate in CDS, will be provided further information at a later time. Potentially, implementation in these two counties will coincide with that in the ISAWS counties described above. In addition, communications have been initiated with CalWIN regarding system changes that will allow Solano and Sonoma Counties, which will be migrating to CalWIN in 2005, to utilize CalWIN for CMSP eligibility processing in accordance with the eligibility changes outlined above.

County welfare directors will be notified through the ACL process of additional information as it becomes available. Future ACLs will contain modifications to the list of policies, new and revised forms, manual changes, training information, etc. Additionally, it is anticipated that provider and beneficiary notifications regarding these changes will be sent out by September 1, 2004.

It would be helpful if your county identified a staff member as a contact for Workgroup and CMSP staff to consult for routine questions and instructions. This person will also be invited to attend any training that may be conducted relating to these changes. In the meantime, counties may monitor the CMSP website (www.cmspcounties.org) for

Board and Eligibility Committee activities relating to eligibility and other important Program issues.

If you have any questions regarding these changes or wish to identify your county contact as discussed above, please call Ms. Genny Fleming at (916) 552-8041, or e-mail at gfleming@dhs.ca.gov.

Sincerely,

Marylyn Willis

Marylyn Willis, Chief
County Medical Services Program Unit

Enclosure

cc: Mr. Lee Kemper
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County Medical Services Program (CMSP)
Reduced Eligibility Certification
Policy Listing
June 16, 2004

The policy places time limits to the certification period of individuals eligible for CMSP. Clients with a share-of-cost (aid code 85 and 89) will be certified for three months. Clients with no share-of-cost (aid codes 84 and 88) will be certified for six months. Clients with emergency services only (aid code 50) will be certified for the month of application plus the following month. Clients in aid code 8F (companion to Medi-Cal aid code 53) are not affected by this policy. (See items 7, 8 and 23 for additional information.)

For all CMSP clients (include aid code 8f) certification periods will not extend beyond the end of the month prior to their 65th birthday.

2 CMSP quarterly status reports and annual redeterminations will be eliminated. (Annual redeterminations will still be required for Aid Code 8F clients since their eligibility is tied to Medi-Cal's Aid Code 53.)

3. For aid code 8F, these clients are required to comply with the Disability & Adult Program Division (DAPD) process for determining if they are disabled, if the disability is expected to last for at least one year or result in death. The County will give the individual a DAPD packet within 10 days of being notified of the individual's entrance into Long Term Care/Skilled Nursing Facility. If the person has been given a DAPD packet to complete and has not done so within the 30 days required, eligibility for CMSP should be terminated with timely notice. If the person has not been given a DAPD packet to complete, then that person is not required to comply. (If that person has a presumptive disability diagnosis, or is receiving a type of income that is based on a Federal disability determination, he/she will not be in aid code 8F/53 in the first place.) Individuals on this aid code are medically indigent (MI) and are eligible in conjunction with their Medi-Cal aid code 53 (MI person in Long Term Care/Skilled Nursing Facility).

4. An individual who is not potentially eligible for Medi-Cal (no linkage or deprivation) can verify Savings Account, Checking Account Fair Market Value (FMV) with the sworn statement on the Statement of Facts as long as they provide the type of account, the account number, bank name and balance. That individual can verify Life Insurance FMV with the sworn statement on the Statement of Facts (SOF) as long as they provide the insurance company name and address, type of insurance (whole or term), the face value and the Cash Surrender Value (CSV). The individual can verify burial insurance and burial trusts with the sworn statement on the SOF as long as they provide the insurance company name and address, the face value and the CSV. The individual can verify non-exempt vehicles with the sworn statement on the SOF as long as they provide enough details for the worker to figure out the FMV (year, make, model). If other members of that individual's family are ineligible for Medi-Cal solely due to failure to provide valid Medi-Cal resource verifications, their

failure to comply will not affect the CMSP individual's CMSP eligibility, unless CMSP also requires this verification.

5. All other property items (stocks, bonds, mutual funds, trusts, real property, etc) and all income items must be verified per the current regulations.

6. Any resource verification that is acceptable for Medi-Cal is acceptable for CMSP.

7 All CMSP certification periods are individual-based. CMSP individuals in the same case, with the same aid code, will have the same certification period. However, individuals in the same case with *different* aid codes may have *different* certification periods.

8. When determining the certification period, the County Welfare Department (CWD) will review the anticipated share of cost based on the most recent information available. Therefore, if the anticipated share of cost (SOC) in the future month is zero, the applicant will be certified for six months. If there is a share of cost in the future month, the certification will be for three months only. Please note, the future month may be either the second or third month depending upon when the application is processed. For full scope aid codes, the future month may not exceed the third month. For aid code 50, the future month may not exceed the second month.

   Example: Application is made in January. If the application is approved in January, the certification period will be based on the share of cost anticipated for February. If the application is approved in February, the certification period will be determined by the anticipated share of cost for March. Note: In this case, January and February may have different budget/SOC than March. Thus, during the certification period, a client may have a different SOC for the months prior to the future month that is used in determining the period.

9. Clients who have a change in income will not have that change applied to CMSP SOC during the existing certification period. If the income goes up, there is no change in the CMSP SOC. If the income goes down, there is no change in the CMSP SOC.

10. Clients who have a change in resources will not have that change applied to CMSP resource eligibility during the existing certification period. If the resources increase, the resource determination does not change and the case is not discontinued. If the resources decrease, the resource determination likewise does not change. (There is also no advantage for anyone to recompute resource eligibility based on lower resources on an approved CMSP case.)

11. Some non-financial changes that have the potential to affect eligibility to CMSP will be applied to CMSP eligibility determinations during the existing certification period Non-financial changes include: change in the County of residence, change of linkage/deprivation, change in cooperation with the DAPD process, incarceration

and loss of contact/returned mail, aid code changes* (i.e., filing a disability application, or full scope client loses Satisfactory Immigration Status (SIS)). If the non-financial change results in ineligibility, CMSP will be discontinued (with timely notice per current regulations). See #16 below for discussion of changes in household composition apart from those that automatically bring Medi-Cal linkage/deprivation with them.

*If a client files a disability application during a certification period, the aid code is changed per current policy. There is no discontinuance required. When a full scope client loses SIS, a timely discontinuance is issued without converting to restricted benefits. The client may reapply for emergency only benefits. Conversely, if an emergency services only client becomes eligible for full scope benefits, the emergency certification period will continue unless the client requests discontinuance and reapplies.

12. Fair Hearings must be requested within 30 days of the date of the notice of action. In order to receive Aid Paid Pending, the request must be made prior to the effective date of the adverse action, in accordance with current regulations. (See #13 for further discussion of Aid Paid Pending.)

13. Aid Paid Pending (APP) can be granted pending a Fair Hearing when an adverse action is taken on an approved case. Aid Paid Pending does not apply in situations where the hearing is requested based on the granting or denying notice(s). Under no circumstance will APP extend beyond the existing certification period, even if the Fair Hearing has not yet concluded. The client can reapply for CMSP after the end of the existing certification, and eligibility will be determined based on the circumstances in the month of reapplication. (If the new application is denied and the client files a Fair Hearing on the new denial, APP is not applicable because there is no existing aid to be continued.)

14. A client can request discontinuance of the CMSP case prior to the end of the certification period.

15. Clients who request discontinuance of the CMSP case prior to the end of the certification period can have the current case terminated and can reapply for the following month. A client's request for CMSP discontinuance is exempt from 10-day notice requirements. If the request is in writing, no discontinuance Notice of Action (NOA) need be sent. If the request is not in writing, a discontinuance NOA must be sent and a request for discontinuance form should also be sent, but the discontinuance at the end of the month in which it is requested should be processed regardless of the mode of the request, the date of the request, or whether or not the individual has returned a completed written request for discontinuance.

16. In the situation where one individual is eligible for CMSP and another individual (a spouse) joins the family and is a manditorily included person in the CMSP Family Budget Unit (CFBU), the existing CMSP eligibility may or may not be discontinued at the end of the month in which the individual joined the family unit.

If the added individual requests CMSP in the month they joined the CFBU, the original beneficiary must request discontinuance effective the same month. Failure to do so will be deemed failure to cooperate and the new family member's application will be denied. Eligibility will be reevaluated for the month and if there is an increase in the SOC, the added person will have the obligation to meet the difference in the new SOC over the old SOC in order to have medical services covered by CMSP. The SOC of the original applicant will not be changed in the month the new person is added. The new eligibility determination will apply to both members of the case in the month following the change. A new certification period will begin in the month following the addition of the new person, and will be based on the aid codes granted at that time.

If the request to add a person occurs after MEDS Renewal, continue to apply the policy as previously described: original person must discontinue, add the new person in the current month and make new determination for both starting the following month. (If there is a change in SOC, a MEDS override should be attempted. If that is not possible, due to an increase in the SOC, the original client will have the previous SOC for the first month of the new certification.)

If the added individual is eligible for Medi-Cal and the existing CMSP client is linked (i.e., deprivation) and joins the Medi-Cal case, the CMSP case must be discontinued the month in which the Medi-Cal application is taken. Failure of the CMSP client to cooperate in determining Medi-Cal eligibility will result in discontinuance.

If the added individual does not wish to apply for CMSP or is applying for Medi-Cal (and the CMSP client is not linked), the CMSP client's existing certification period remains intact. If the CMSP client applies again after that period, the determination will consider the new Family Budget Unit (FBU) composition.

17. Applications for CMSP may be taken one month prior to the month in which the client wants benefits to begin. This will primarily be done in situations where the certification period is ending and the client wishes to reapply in the final month of the certification period so that benefits will continue virtually uninterrupted for another certification period. It may also occur in those situations where the client requests discontinuance in one month so that more beneficial circumstances such as reduced income can be applied to the eligibility/SOC determination for the re-application for the future month. This ability to apply for a future month is also available for clients who have not already been receiving CMSP, but for some reason want the benefits to begin in the future month. In no circumstance will the certification period begin later than the month following an application. CMSP benefits will only begin in the application month or in the month following the application month.

18. An individual who has linkage to Medi-Cal must comply with all Medi-Cal requirements. If the individual does not provide resource verifications for Medi-Cal, that person cannot be eligible for CMSP, based on non-compliance with Medi-Cal eligibility criteria. This is existing regulation, but is included here for clarification.

19. A client who voluntarily excludes a child from the Medi-Cal application and thereby eliminates his/her own deprivation/linkage to Medi-Cal cannot be eligible for CMSP based on that lack of linkage. For CMSP non-financial purposes, that individual is still considered to have Medi-Cal deprivation linkage. This is existing regulation, but is included here for clarification.

20. When a client who has been receiving Medi-Cal is discontinued from Medi-Cal, CMSP will not be automatically evaluated. A new application for CMSP is required, and CMSP eligibility will be evaluated based on the circumstances in the application month.

21. When a client who has been receiving CMSP meets Medi-Cal linkage/deprivation criteria, Medi-Cal will be automatically evaluated. Those requirements that are applicable for a new Medi-Cal/CMSP application (Medi-Cal property verification standards, DAPD, DA cooperation, etc.) will be applied, and if the client does not cooperate or verifications do not meet the Medi-Cal threshold, CMSP will be discontinued (with timely notice).

22. In no event, shall a backdated CMSP application be taken as a result of an applicant failing eligibility from a backdated CalWORKS application due to QR/PB. Example: Client reports on a QR7 submitted in 8/04 that the father of the CalWORKS aided children moved into the home in 6/04. The worker will determine eligibility to Medi-Cal for the father effective 6/04. If the father is not Medi-Cal eligible, he cannot be granted CMSP for this back period. A separate CMSP application must be made and the date of the application can be no earlier than the month the CWD was **notified** that the father returned to the home and was requesting aid.

23. Income will be limited to 200% Federal Poverty Level (FPL). In addition to the existing property requirements for eligibility to CMSP, applicants will be restricted by income limits. This policy's intent is to limit eligibility to no greater than 200% of the FPL as determined each year. When determining CMSP budgets for purposes of applying the 200% test, counties are instructed to use the COLA increase for SSA, and to allow for other health coverage premium deduction. This policy will become effective on the same date as when the Reduced Eligibility Certification policies are implemented.

    The CWD will work the application according to REC policies first. Initially, budgets would be developed, determining net non-exempt income, for the application month and the future month(s) (including intervening months). Then the income test of 200% FPL would be applied to each of those months. If successful, then the CWD would proceed with determining SOC. Therefore, while a client could be eligible and certified for CMSP under the REC policy, there may be one or more months during the period that he/she would not be eligible based on the income test. However, the income test will not be applied beyond the application processing months once the case is certified.

Sneede requirements limit financial responsibility to spouse for spouse and parent for child and is applied in SOC determinations. The income test will be applied to the net non-exempt income of the CFBU (without Sneede adjustments). If the applicant passes the income test, Sneede may then be applied as usual for SOC determinations. Sneede procedures do not apply to the 200% FPL test. (Please note that eligibility requirements for property remain unchanged. Counties should continue to determine a client's property in the same manner it did prior to this policy.)

Example 1:
Client applies for CMSP in January. Client is over 200% in January and under 200% in February. January benefits are denied. If client has a share of cost in February, the cert period would be February & March. If there were no share of cost in February, the cert period would be through June.

Example 2:
Client applies in January. Client is under 200% in January but over 200% in February and ongoing. CMSP will be approved for January only and denied for February and March.

Example 3:
Client applies in January but requests benefits to begin February. Client is over 200% for February but under 200% for March. February benefits are denied. If there were a share of cost in March, the cert period would be March & April. If there were no share of cost in March, the cert period would be through July.

Example 4:
Client applies in January and requests benefits to begin February. Client is under 200% for February but over 200% beginning March. Benefits will be approved for February only and denied for March & April.

Note: At it's meeting on March 25, 2004, the Governing Board approved the original version of the policy list, dated March 17, 2004. Since that time, the following actions occurred:

Eligibility Committee made several modifications on May 19, 2004

- Eligibility Committee made one modification to #23 on June 16, 2004